STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

NARRATIVE FOR THE AMOUNT, DURATION AND SCOPE OF SERVICES

General

The provision of the following medically necessary services cannot be reimbursed except when they are ordered or prescribed, and directed or performed within the scope of the license of a practitioner of the healing arts: laboratory and x-ray services, family planning services, and home health services. Physical therapy services will be reimbursed only when prescribed by a physician. Inpatient acute hospitalizations will be reimbursed only if the stay has been authorized.

12 VAC 30-50-100.
Inpatient hospital services provided at general acute care hospitals and free-standing psychiatric hospitals.

A. Enrolled providers.

1. Preauthorization of all inpatient hospital services will be performed. This applies to both general acute care hospitals and free-standing psychiatric hospitals. Non-authorized inpatient services will not be covered or reimbursed by the Department of Medical Assistance Services (DMAS). Preauthorization shall be based on criteria specified by DMAS. In conjunction with pre-authorization, an appropriate length of stay will be assigned when required, using the current HCIA Length of Stay by Diagnosis and Operation as guidelines.

a. Admission review.

(1) Planned/scheduled admissions. Review shall be done prior to admission to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned at the time of this review until such time as DMAS goes to a Diagnostic Related Grouping (DRG) payment methodology. At such time, only psychiatric hospitalizations will be assigned an initial length of stay. If the admission is for a surgical procedure that requires prior authorization, the hospital must ensure that the physician has obtained the prior authorization for the planned procedure from DMAS before the request for authorization of the hospital admission is made. (Refer to 12 VAC 30-50-140) Adverse authorization decisions shall have available a reconsideration process as set out below.

(2) Unplanned/urgent admissions. Review shall be performed within one working day to determine that inpatient hospitalization is medically justified. An initial length of stay shall be assigned for those admissions

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which have been determined to be appropriate, until such time as DMAS goes to a full DRG payment methodology. At such time, only psychiatric admissions shall have an initial length of stay assigned. Adverse authorization decisions shall have available a reconsideration process as set out below.

b. Concurrent review. Concurrent review shall be done to determine that inpatient hospitalization continues to be medically necessary. Prior to the expiration of the previously assigned initial length of stay, the provider shall be responsible for obtaining authorization for continued inpatient hospitalization. If continued inpatient hospitalization is determined necessary, an additional length of stay shall be assigned. Concurrent review shall continue in the same manner until the discharge of the patient from acute inpatient hospital care. Adverse authorization decisions shall have available a reconsideration process as set out below. This element of review shall end for non-psychiatric claims with the full implementation of the DRG reimbursement methodology.

c. Retrospective review shall be performed when a provider is notified of a patient's retroactive eligibility for Medicaid coverage. It shall be the provider's responsibility to obtain authorization for covered days prior to billing DMAS for these services. Adverse authorization decisions shall have available a reconsideration process as set out below.

d. Reconsideration process.

(1) Providers requesting reconsideration must do so upon verbal notification of denial.

(2) This process is available to providers when the nurse reviewers advise the providers by telephone that the medical information provided does not meet DMAS specified criteria. At this point, the provider must request by telephone a higher level of review if he disagrees with the nurse reviewers' findings. If higher level review is not requested the case will be denied and a denial letter generated to both the provider and recipient identifying appeal rights.

(3) If higher level review is requested, the authorization request will be held in suspense and referred to the Utilization Management Supervisor (UMS). The UMS shall have one working day to render a

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decision. If the UMS upholds the adverse decision, the provider may accept that decision and the case will be denied and a denial letter identifying appeal rights will be generated to both the provider and the recipient. If the provider continues to disagree with the UMS' adverse decision, he must request physician review by DMAS Medical Support. The case remains in suspense and is referred to DMAS Medical Support for the last step of reconsideration.

(4) DMAS Medical Support will review all case specific medical information. Medical Support shall have two working days to render a decision. If Medical Support upholds the adverse decision, the request for authorization will then be denied and a letter identifying appeal rights will be generated to both the provider and the recipient. The entire reconsideration process must be completed within three working days.

e. Appeals process.

(1) Recipient appeals. Upon receipt of a denial letter, recipient shall have the right to appeal the adverse decision. Under the Client Appeals regulations, at 12 VAC 30-110-Part I the recipient shall have 30 days from the date of the denial letter to file an appeal.

(2) Provider appeals. If the reconsideration steps are exhausted and the provider continues to disagree, upon receipt of the denial letter, the provider shall have 30 days from the date of the denial letter to file an appeal if the issue is whether DMAS will reimburse the provider for services already rendered. The appeal shall be held in accordance with *Code of Virginia* §9-6.14:1 *et seq.*

2. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

3. Reimbursement for induced abortions is provided in only those cases in which there would be substantial endangerment to health or life of the mother if the fetus were carried to term.

4. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60 day period for the same or similar diagnosis and/or treatment plan. The 60 day period would begin on the first hospitalization (if there are multiple

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admissions) admission date. There may be multiple admissions during this 60 day period. Claims which exceed 21 days per admission within 60 days, for the same or similar diagnosis, and/or treatment plan, will not be authorized for payment. Claims which exceed 21 days per admission within 60 days with a different diagnosis and/or treatment plan, will be considered for authorization, if medically indicated. Except as previously noted, regardless of authorization for the hospitalization, the claims will be processed in accordance with the limit for 21 days in a 60 day period. Claims for stays exceeding 21 days in a 60 day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days for non-psychiatric admissions shall cease when DMAS implements a Full DRG payment methodology.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary hospitalizations in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological/psychiatric, examination. The admission and length of stay must be medically justified and pre-authorized via the admission and concurrent or retrospective review processes described above. Medically unjustified days in such hospitalizations shall not be authorized for payment.

5. Mandatory lengths of stay.

   a. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically justified.

   b. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the Diagnosis Related Grouping methodology is fully implemented. Nothing in this regulation shall be construed as requiring the provision of inpatient coverage where the attending physician in

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consultation with the patient determines that a shorter period of hospital stay is appropriate.

6. Coverage in freestanding psychiatric hospitals shall not be available for individuals aged 21 through 64. Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all Medicaid eligible individuals, regardless of age, within the limits of coverage prescribed in this section and 12VAC30-50-105.

7. For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, or leukemia. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS medical support. Inpatient hospitalization related to kidney transplantation will require preauthorization at the time of admission and, concurrently, for length of stay. Cornea transplants do not require preauthorization of the procedure, but inpatient hospitalization related to such transplants will require preauthorization for admission and, concurrently, for length of stay. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart, and bone marrow transplant/ stem cell services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined, procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover procurement costs; all hospital costs from admission to discharge for the transplant procedure; and total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee reimbursement does not include pre- and post-hospitalization for the transplant procedure or pretransplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures

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performed in the Commonwealth. Reimbursement for covered kidney and cornea transplants is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-570.

8. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed shall be subject to review. Hospitals must submit the required DMAS forms corresponding to the procedures. Regardless of authorization for the hospitalization during which these procedures were performed, the claims shall suspend for manual review by DMAS. If the forms are not properly completed or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

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shall suspend for manual review by DMAS. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to DMAS policy.

12 VAC 30-50-105.

B. Non Cost Reporting Providers. (Non-participating/out of state).

1. Inpatient hospital services, when rendered by non cost reporting providers, shall not require preauthorization with the exception of transplants as described in subsection 10 below. Inpatient hospital services claims will be suspended from payment and manually reviewed for medical necessity as described in subsections 2-10 below using criteria specified by DMAS until such time as DMAS implements full DRG payment methodology. At such time, all inpatient hospital services claims from non-cost reporting providers will suspend from payment and shall be manually reviewed for medical necessity of the admission for non-psychiatric hospital stays and for medical necessity for the admission and length of stay for psychiatric hospital stays using criteria as designated by DMAS.

2. Medicaid inpatient hospital admissions (lengths-of-stay) are limited to the 75th percentile of PAS (Professional Activity Study of the Commission on Professional and Hospital Activities) diagnostic/procedure limits. For admissions under four days that exceed the 75th percentile, the hospital must attach medical justification records to the billing invoice to be considered for additional coverage when medically justified. For all admissions that exceed three days up to a maximum of 21 days, the hospital must attach medical justification records to the billing invoice. (See the exception to subsection seven of this section.) Inpatient hospital services will be reviewed for appropriateness of the admission and length of stay.

3. Cosmetic surgical procedures shall not be covered unless performed for physiological reasons and require DMAS prior approval.

4. Reimbursement for induced abortions is provided in only those cases in which there would be a substantial endangerment to health or life of the mother if the fetus were carried to term.

5. Hospital claims with an admission date prior to the first surgical date, regardless of the number of days prior to surgery, must be medically justified. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement for all pre-operative days. Medically justified situations are those

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length of stay must be medically justified and preauthorized via the admission and concurrent review processes described in subsection A of 12VAC30-50-100. Claims for stays exceeding 21 days in a 60-day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease with dates of service on or after July 1, 1998. Medically unjustified days in such hospitalizations shall not be reimbursed by DMAS.

EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age who are Medicaid eligible for medically necessary stays in general hospitals and freestanding psychiatric facilities in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of health conditions identified through a physical or psychological, as appropriate, examination.

I. Mandatory lengths of stay.

1. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

2. Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for either radical, modified, total, or partial mastectomies may be covered if medically justified and prior authorized until the diagnosis related grouping methodology is fully implemented. Nothing in this chapter shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

J. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS outpatient surgery list unless the inpatient stay is medically justified or meets one of the exceptions.

K. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, or leukemia. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart, bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of

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where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admissions will be denied.

6. Reimbursement will not be provided for weekend (Saturday/Sunday) admissions, unless medically justified. Hospital claims with admission dates on Saturday or Sunday will be pended for review by medical staff to determine appropriate medical justification for these days. The hospital must write on or attach the justification to the billing invoice for consideration of reimbursement coverage for these days. Medically justified situations are those where appropriate medical care cannot be obtained except in an acute hospital setting thereby warranting hospital admission. Medically unjustified days in such admission will be denied.

7. Coverage of inpatient hospitalization shall be limited to a total of 21 days per admission in a 60 day period for the same or similar diagnosis and/or treatment plan. The 60 day period would begin on the first hospitalization (if there are multiple admissions) admission date. There may be multiple admissions during this 60 day period. Claims which exceed 21 days per admission within 60 days, for the same or similar diagnosis, and/or treatment plan, will not be reimbursed. Claims which exceed 21 days per admission within 60 days with a different diagnosis and/or treatment plan, will be considered for reimbursement, if medically justified. The admission and length of stay must be medically justified and pre-authorized via the admission and concurrent review processes described above. Claims for stays exceeding 21 days in a 60 day period shall be suspended and processed manually by DMAS staff for appropriate reimbursement. The limit for coverage of 21 days shall cease for non-psychiatric hospitalizations at such time as DMAS implements Full DRG payment methodology.

   EXCEPTION: SPECIAL PROVISIONS FOR ELIGIBLE INDIVIDUALS UNDER 21 YEARS OF AGE: Consistent with 42 CFR 441.57, payment of medical assistance services shall be made on behalf of individuals under 21 years of age, who are Medicaid eligible, for medically necessary hospitalizations in excess of 21 days per admission when such services are rendered for the purpose of diagnosis and treatment of conditions identified through a physical or psychological/ psychiatric examination.

8. Coverage for a normal, uncomplicated vaginal delivery shall be limited to the day of delivery plus an additional two days unless additional days are medically justified. Coverage for cesarean births shall be limited to the day of delivery plus an additional four days unless additional days are medically necessary.

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9. Reimbursement will not be provided for inpatient hospitalization for those surgical and diagnostic procedures listed on the DMAS–outpatient surgery list unless the inpatient admission is medically justified or meets one of the exceptions.

10. For purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys and corneas shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma or breast cancer. Transplant services for liver, heart, and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Kidney, liver, heart and bone marrow/stem cell transplants and any other medically necessary transplantation procedures that are determined to not be experimental or investigational require preauthorization by DMAS. Cornea transplants do not require preauthorization. The patient must be considered acceptable for coverage and treatment. The treating facility and transplant staff must be recognized as being capable of providing high quality care in the performance of the requested transplant. Reimbursement for covered liver, heart and bone marrow/stem cell transplant services and any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be a fee based upon the greater of a prospectively determined, procedure-specific flat fee determined by the agency or a prospectively determined procedure-specific percentage of usual and customary charges. The flat fee reimbursement will cover: procurement costs; all hospital costs from admission to discharge for the transplant procedure; total physician costs for all physicians providing services during the transplant hospital stay, including radiologists, pathologists, oncologists, surgeons, etc. The flat fee does not include pre- and post-hospitalization for the transplant procedure or pre-transplant evaluation. If the actual charges are lower than the fee, the agency shall reimburse actual charges. Reimbursement for approved transplant procedures that are performed out of state will be made in the same manner as reimbursement for transplant procedures performed in the Commonwealth. Reimbursement for covered kidney and cornea transplant is at the allowed Medicaid rate. Standards for coverage of organ transplant services are in 12VAC 30-50-540 through 12VAC30-50-570.

11. Coverage of observation beds. *Reserved.*

12. In compliance with federal regulations at 42 CFR 441.200, Subparts E and F, claims for hospitalization in which sterilization, hysterectomy or abortion procedures were performed, shall be subject to review of the required DMAS forms corresponding to the beforementioned procedures. The claims shall suspend for manual review by